CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/13/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155206	B. WING			03/25/2	011
NAME OF I	PROVIDER OR SUPPLIER	" {	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•	
					ORNADAY ROAD		
BROWN	SBURG HEALTH C	ARE CENTER		BROW	NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	COMPLETION DATE
IAG	REGULATORY OR	LISC IDENTIFFING INFORMATION)		IAG	DEI TOLERO I I		DATE
F0000	This visit was fo	or the investigation of	F000	00	Submission of this Plan of		
	complaints IN00	087244 and IN00087467.			Correction shall not constitute be construed as an admission		
					Brownsburg Health Care Cent		
	1 ^	087244 - Substantiated,			that the allegations contained		
		iciencies related to the			the survey report are accurate		
	~	ted at F-271, F-281,			reflect accurately the provision of Nursing Care and Service to		
	F-328, F-431, an	nd F-441.			the residents of Brownsburg	-	
	Complaint DIOO	0070167 Substantists 1			Health Care Center.		
		0872467 - Substantiated, iciencies related to the					
		ted at F-157, F271, F-282,					
	and F-328.	ωα αι Γ-131, ΓΔ/1, Γ-2δ2,					
	and F-326.						
	1 *	rch 22, 23, 24, and 25,					
	2011						
	Facility number:	000113					
	Provider number						
	AIM number: 10						
	Survey team:						
	DeAnn Mankell,	, RN, TC					
	Courtney Hamilt	ton, RN (March 24 and					
	25, 2011)						
	Canqua had turna						
	Census bed type SNF: 4						
	SNF. 4 SNF/NF: 12	6					
		30					
	10ta1. 1	JU					
	Census payor typ	ne·					
	Medicare: 17	γ•.					
	Medicaid: 91						
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

UIDR11

Facility ID: 000113

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. E			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED 03/25/2011				
	PROVIDER OR SUPPLIER		STREET A 1010 H	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD NSBURG, IN46112	I		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Other: 22 Total: 130						
	Sample: 12						
		es also reflect state accordance with 410 IAC					
	Quality review com Bev Faulkner, RN	pleted on March 31, 2011 by					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155206	B. WING			03/25/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1010 H	ORNADAY ROAD		
	SBURG HEALTH CA	ARE CENTER			NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X:	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT		
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DAT	
F0157	Based on recor	rd review and	F01	57	What corrective action(s) will be accomplished for those reside		/2011
SS=D	interview, the	facility failed to			found to be affected by the		
	notify the phys	sician of a resident's			deficient practice?It is the police	;y	
	low blood suga	ar for 1 of 3 residents			of the facility that the resident,		
	_	injections and for a			resident legal representative a physician is notified of any	iu	
	_	turation level with a			changes/decline/room move,		
		y rate for 1 of 4			etc.Resident #B is a very brittle	÷	
					diabetic who is non-compliant with diet. His family brings in a	nd	
	residents with	respiratory needs in a			feeds him food that is not on h		
	sample of 12 (Resident B).			diet. The 24 hour report for the		
					resident does indicate the		
	Findings inclu	de:			physician was called on 3/10/2	l l	
	Tillulings illelu	de.			at 3am with no new orders giv	I .	
					at that time. The physician wa called again on 3/10/11 at 8an	I .	
	1. Resident B's	s clinical record was			and was then sent to the hosp		
	reviewed on 3/	/22/11 at 5:38 P.M.			for evaluation. All licensed nur	I .	
	and again on 3	2/23/11 at 1:30 P.M.			have been inserviced on the		
	ana agam on s	723/11 at 1.30 1.1VI.			facility policy for physician		
					notification and proper documentation of the notificati	an	
	Resident B's d	iagnoses included,			from 3/23/11 and ongoing. All	⁷¹¹	
	but were not li	mited to insulin			admission and change of		
	dependent dial	betes, deep vein			condition incidents will be		
	thrombosis, de	•			followed up by the DON/desig	l l	
	· ·	,			on a daily basis by checking o	l l	
	hypertension,	COPD (chronic			the 24 hour report and review all admissions, transfers and	ЭΪ	
	obstructive pul	lmonary disease), and			discharges and the Diabetic F	ow	
	Parkinson's dis	sease.			Sheet for call order	-	
					compliance.How will other		
	Daview of Dee	sident B's nurses			residents affected by the same	!	
					deficient practice be identified	uill	
	notes indicated	1:			and what corrective action(s) when the taken? All residents have the	l l	
	03/09/2011 at	10:00 P.M., "@ (at) 4			potential to be affected by the	–	
		ed res. room & found			deficient practice. No othe		
		and the second			resident's were affected by the		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	LDING		COMPL	ETED
		155206	B. WIN		-	03/25/2	011
			_	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	NAME OF PROVIDER OR SUPPLIER			1010 H	ORNADAY ROAD		
	SBURG HEALTH C	CARE CENTER		1	NSBURG, IN46112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	•	R LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE
	res. unrespons	sive & diaphoretic.			practice. Staff inservicing was started on 3/23/11 and is ongo		
	B/S (blood su	gar) 41. Res was			on the facility policy for physic	-	
	· ·	vanilla pudding & 120			notification, call orders and wl		
		timeters) Ensure over			to document that the physicia		
	,	· ·			was notified and the response		
	`	ite) time frame. B/S			Also inserviced to policy to no	otify	
	gradually rose	e to 72 and res became			Medical Director if unable to reach the resident's physician		
	responsive to	name. Skin was			Documentation of charting will		
	1 1	acked speakers c			monitored to reflect that		
		_			notification has been verified		
		answered questions			the response. The 24 hour rep		
	appropriately	- 4 P insulin held.			will be monitored daily as well the Diabetic Flow Sheet, call	as	
	Res. consume	ed 75% of supper c			orders and all Admissions,		
	(with) 240 cc	fluid intake. 9P B/S			discharges and transfers, on a	а	
	261. HS (bed				daily basis by the DON/design	nee	
	`				to ensure compliance.What		
	administered	as ordered."			measures will be put into place		
					and what systemic changes we be made to ensure that the	/11	
	Review of the	physician's orders for			deficient practice does not		
		ndicated an order for			recur?Staff inservicing was do	one	
					on 3/23/11 and is ongoing on	_	
		A, 11 A, 4 P, 9 P,			facility policy for notification of	f	
		(less than) 60 or >			physicain for changes in condition, call orders, etc. The	۵	
	(greater than)	300."			DON/designee will monitor the		
					hour report, Diabetic Flow		
	The nurses' no	otes lacked any			Sheets, call orders and all		
		•			admissions,		
		e physician being			discharges,transfers and documentation for follow-up o	n a	
	notified of the	e residents low blood			daily basis to ensure	ıı a	
	sugar.				compliance.How will the		
					corrective action(s) be monitir		
	The nurses' no	otes indicated:			to ensure the deficient practic		
					will not recur, ie, what Quality Assurance Program will be pu		
	03/10/2011 at	2:45 A.M., "Assessed			into place and the completion		
					Figure 2.13 the completion		
					<u> </u>		

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206			A. BUILDING			survey leted 011
NAME OF	PROVIDER OR SUPPLIE	R	-		ADDRESS, CITY, STATE, ZIP CODE	<u>!</u>	
BROWN	SBURG HEALTH C	CARE CENTER		1	ORNADAY ROAD NSBURG, IN46112		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF REGULATORY OF REGULATORY OF REGULATORY OF RESPONDENT AND THE RESPONDENT OF R	gar) at 252. Ind warm to touch. It a couple tries. Its for general Administered MAPAP In a couple tries. Its for general In a couple tries. In a c		ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY) date?The DON/designee will monitor the 24 hour reports, admissions, discharges, transfers and Diabetic Flow Sheets as well as documentarelated to them on a daily barensure compliance. Any continued concerns will be addressed in the monthly Quantum Assurance Meeting via a write action plan. The plan will be monitored by the Administrator/DON/designeed resolution occurs.	ation sis to ality tten	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO LDING	NSTRUCTION	COMPL	ETED
		155206	B. WING			03/25/2011	
NAME OF P	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
BROWNS	SBURG HEALTH CA	ARE CENTER		1	ORNADAY ROAD NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	1000110, 11140112		(V5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΙΤΕ	DATE
	notified of the	resident's respiratory	ĺ				
	rate or the low	oxygenation levels.					
	Review of the	physician's orders for					
		dicated the lack of an					
		en administration.					
		,					
	The nurses not	tes indicated:					
		7:45 A.M., "B/P					
		R 30, Sats 83% on 3					
		I/C. Res. is awake.					
	-						
	-	esponsive as normal.					
		(name of son) &					
	` 1 3	ician). May send to					
	, , ,	mergency room) for					
		A BS 274. BS at this					
	` /	had (sic) been 40 @					
	4 p. 3-10 (sic)	-					
	=	P.M. Insulin (sic)					
	healed (sic)."						
	03/10/2011 2:4	45 P.M., "res.					
	admitted to (na	ame of hospital).					
	nurse (sic) uns	sure of admitting dx.					
	(diagnoses) be	eing tx'd (treated) for					
	pneumonia &	UTI (urinary tract					
	infection)."	· •					
	,						

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206			ILDING	NSTRUCTION	(X3) DATE S COMPL 03/25/2	ETED
			B. WIN		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				DRNADAY ROAD		
BROWN	SBURG HEALTH CA	ARE CENTER		BROWN	ISBURG, IN46112		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	During an inte	rview with the DON					
	(Director of N	urses) on 3/24/2011					
	at 2:45 PM, sh	e indicated the					
	physician shou	ıld have been called					
	about the low	blood sugar and the					
	respiratory rate	e, but she did not					
	know if he had	l been called.					
		undated policy for					
	•	hange of Condition:					
	1	ification" provided by					
		f Nurses on 3/24/11 at					
		cated, "The attending					
	1 ^ *	be notified of a					
		sident's condition by					
	a licensed staf						
	warranted 1						
		to include but is not					
		Significant change					
	in/or unstable	vital signs."					
		C					
		g refers to complaint					
	IN00087467.						
	2 1 5(a)(2)						
	3.1-5(a)(2) 3.1-5(a)(3)						
	3.1 - 3(a)(3)						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPLETED	
		155206	B. WING			03/25/2011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			1010 H	ORNADAY ROAD		
	SBURG HEALTH CA				NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	F02/	TAG	It is the policy of the facility that	.+	DATE
F0271		rvation, interview,	F02'	/1	when a resident is	11.	04/15/2011
SS=D		iew, the facility			admitted/readmitted that the		
		n orders for current			facility receives and verifies all orders for the residents		
		eing administered,			care. Resident #B retirned from	n	
	oxygen, and a	dressing change			the hospital and orders were		
	upon the readr	mission of 2 of 3			verified by the nurse, including orders from prior to the		
	residents to the	e facility in a sample			hospitalization to verify for		
	of 12 (Residen	its B and C).			continuation/discontinuation. T		
	(nurse documented that she ha	-	
	Fin din ee in ele	4.4.			verified with the physician. The residents physician follwed him		
	Findings inclu	ded.			while he was in the hospital ar		
					signed his discharge orders.		
	1. Resident B	's clinical record was			When writing the orders the nu		
	reviewed on 3	/22/11 at 5:38 P.M.			failed to write the order for Niz cream and Granulex(both wer		
	and again on 3	2/23/11 at 1:30 P.M.			from before the hospitalization		
	una ugam on s	723/11 at 1.301			She transcribed to the new	,	
	Dazidant Dla d	::			Medication Administration Rec		
		iagnoses included,			but did not write the order. On 3/15/11, the residents son		
	but were not li	mited to insulin			requested that he receive oxyg	gen	
	dependent dial	betes, deep vein			to him more comfortable. The	,	
	thrombosis, de	ementia,			oxygen was applied as a nursi	-	
		COPD (chronic			measure but an order was not		
	,	lmonary disease), and			obatined within 24 hours to maintain the oxygen. An order		
	•	• //			was obtained on 3/27/11 for th		
	Parkinson's dis	sease.			oxygen and orders were writte		
					for the Nizoral cream and		
	Resident B had	d been transferred to			Granulex as well.Staff were inserviced on 3/23/11 and		
	the hospital on	March 10, 2011 and			ongoing on verification of		
	_	the facility on			physician orders and checking	to	
	March 15, 201	*			ensure all orders have been		
					written as well as placed on th Medication Administration	e	
	medication and	d treatment orders.			Record. The LPN involved has	.	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155206	B. WIN			03/25/2011	
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				ORNADAY ROAD		
BROWNSBURG HEALTH CARE CENTER					NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE	
					received disciplinary action an		
	Review of the	MAR for March			has been inserviced on physic order verification and transcrib		
	15 23 2011 in	dicated orders for:			of orders. All	mig	
	1				admission/readmission oders	will	
		n. apply to red areas			be checked for correctness by	,	
	on face BID."	This medication had			DON/designee when they		
	been charted a	s applied on 3/16,			occur.Resident #C returned from	I	
		9 at 9 AM,m 3/20,			the hospital with a PermaCath place. He had been receiving	ım	
	1 ' '				dialysis at the hospital and it h	ad	
	3/21, 3/22, and	d 3/23 in the morning.			been discontinued. He returned		
					with orders not to dc the cathe	eter.	
	"Granulex to b	oil heels as			The facility Nurse Practitioner		
	nreventative C	O. (every) shift." This			reviewed the discharge orders		
	^				and did not write any orders to)	
	medication had	d been charted as			remove the Permacath. The catheter had not been flushed	ot	
	applied on 3/1	6, 3/17, 3/18, 3/19,			the hospital and there were no	I	
	3/20 3/21 3/2	2, and 3/23 for the			flush orders when admitted.	´	
	first 2 shifts.	-, 4114 57 25 151 1116			Further follow-up with the hos	pital	
	11151 2 5111115.				revealed that the catheter was		
					in place for 2 reasons: 1)family	· I I	
	"O2 (oxygen)	cont. @ 2 L per NC			was considering possibly taking		
	(nasal cannula)." This medication			out of state and restarting dial and 2)it was felt the resident w	· I	
	, `	<i>'</i>			to weak to survive having the	143	
		ted as applied on 3/17			catheter removed. The site wa	as	
	on the 7-3 and	3-11 shifts, 3/18 on			checked every shift and the		
	all 3 shifts, on	3/19 on the 11-7 and			dressing changed whe soiled.		
	3-11 shift on 3	3/20 on all 3 shifts,			The nurse did not write		
		-7 and 3-11 shifts,			specifically to change the dressing the on the site. The		
		· ·			order was written to state: che	ock	
	3/22 on all 3 s	hifts, $3/23$ on the			site every shift and change		
	11-7 shift.				dressing if soiled. Resident		
					showed no signs/symptoms of	f	
	Davier of the	nhygioionla			infection at the site. Urology w		
	Review of the	. .			called and the Permacath was		
	re-admission of	orders for 3/15/2011			removed on 3/28/11 by urolog	·	
					Inservicing was done on 3/23/	"	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE S COMPL	
AND FLAIN	OI CORRECTION	155206	1	A. BUILDING			
		100200	B. WIN			03/25/2	011
NAME OF	PROVIDER OR SUPPLIE	₹		1	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD		
BROWN	SBURG HEALTH C	ARE CENTER		1	NSBURG, IN46112		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	\top	ID	PROVIDENCE N. AV OF CORRESPOND		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	indicated the l	ack of an order for			and is ongoing on verification	of	
	the Nizoral an	d Granulex. Further			orders, writting clear, concise orders and transcribing orders	to	
	review of the	physician's orders			the MAR/TAR.How will other		
	1	ack of an order for			residents affected by the same		
		3/15/2011 through			deficient practice be identified and what corrective action(s) v		
	3/17/2011.	1 3/13/2011 unougn			be taken?All residents hav eth		
	3/1//2011.				potential to be affected by the		
	<u> </u>				practice. No other residents w	ere	
	1	erview on 3/23/2011			affected by the practice. Staff inservicing was done on 3/23/	11	
	at 2:45 P.M.,	with ADON #1, she			and is ongoing on verification		
	indicated she	was unable to find the			orders, correct transcribing an		
	orders for the	Nizoral cream,			documentation. DON/designed will monitor all	е	
	Granulex, and	•			admission/readmission orders	for	
		tine only gen.			verification, correctness and		
	2 Davidant C	a mi alut arrla al arriam			documentation. DON/designed		
	1	s right subclavian			monitors all orders daily and w check for correctness and	/111	
	1 ~	e was observed with			follow-through.What measure((s)	
	LPN #5, on 3/	24/2011 at 10:55			will be put into place and what		
	A.M., she indi	icated she had			systemic changes will be madensure that the deficient practi		
	changed the d	ressing that morning			does not recur?Staff inservicing		
	as it looked as	if it needed it. She			was donme from 3/23/11 and	is	
	indicated it ha	d last been changed			ongoing on verification and		
	1	She indicated she			documentation orders for admission/readmissions and in	n	
					general. DON/designee will ch		
	1	when the permacath			all orders daily as well as		
	1	ned, but she thought it			admission/readmission orders when they occur for correctnes		
	should be flus	hed at least every			and appropriate transcription t		
	shift.				the MAR/TAR.How will the		
					corrective action(s) be monitor		
	Resident C ha	d been readmitted to			to ensure the deficient practice does not recur, ie, what Qualit		
		02/25/2011. He was			Assurance Program will be pu		
		02,20,2011. 110 was			into place and the completion		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 03/25/2011		
	PROVIDER OR SUPPLIER SBURG HEALTH CA		10	010 HC	DDRESS, CITY, STATE, ZIP CODE DRNADAY ROAD ISBURG, IN46112	00,20,2	· · ·
	SBURG HEALTH CASUMMARY S (EACH DEFICIENT REGULATORY OR had a right subplace, which had been stopp returned to the Resident C's conceive wed on 3 and additional 1/24/11 at 9:15. Resident C's distribution but were not list hypertension, and dementia, and Resident C's personal February 25, 2 had an order for subclavian pershift for rednesses placement." Review of the administration	ARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Declavian permacath in ad been used for a dialysis treatments bed before he a facility. Ilinical record was /22/11 at 7:05 P.M. ly reviewed on 5 A.M. iagnoses included, mited to, multiple myeloma, C-diff. chysician's orders for 2011 and March 2011 by "Check (R) (right) macath q (every) ss, swollen, drainage,	10 B III PRE	010 HC ROWN	DRNADAY ROAD	as lers e lity en	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M A. BUII		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		155206	B. WIN			03/25/2	011
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1010 HORNADAY ROAD BROWNSBURG, IN46112				
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIENT REGULATORY OR These orders Is change the dre catheter. Review of the provided by the on 3/25/2011 a Physician's order.	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) acked an order to essing or to flush the undated policy, the MDS coordinator at 10:15 A.M., for "1. ders/transcribing for		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΝΤΕ	(X5) COMPLETION DATE
	the following 'Orders do not resident the Phacalled and ordetelephone 2 included in the	e Orders (not an allRoutine and PRN edications,					
	on 3/24/2011 a indicated the per wanted the per She indicated						

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER		1010 H	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD NSBURG, IN46112	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)) BE	(X5) COMPLETION DATE
	complaints IN IN00087244.	00087467 and				
	3.1-30(a)					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLI	
		155206	B. WIN			03/25/20)11
NAME OF F	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
				l	ORNADAY ROAD		
BROWNS	SBURG HEALTH CA	ARE CENTER		BROWI	NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
F0281	REGULATORY OR LSC IDENTIFYING INFORMATION) Based on interview and record		F02		What corrective action(s) will b	ne l	04/15/2011
			FU2	01	accomplished for those reside		04/13/2011
SS=D	, and the second second	cility failed to ensure			found to be affected by the		
	a pain patch w	as applied by a			deficient practice?It is the police	су	
	licensed staff r	member for 1 of 3			of the facility that services provided meet professional		
	residents in a s	sample of 12			standards.Resident #A receive	ed a	
	(Resident A).				Lidoderm patch. Patches and	all	
	(======================================				medications ar eto be administered by a licensed nur		
	Eindings inclu	da			or qualified medication	56	
	Findings inclu	de.			aide(QMA). RN#2 has been		
					disciplined and reinserviced or	ו ו	
	1. During the	facility tour on			the fsacility medication administration policy. Inservicing	na	
	3/22/2011 at 2	:43 PM, with RN #1,			was done on 3/23/11 and is	lig	
	she didn't indi	cate Resident A had			ongoing on the facility medicat	ion	
	pain issues.				administration policy. Other		
	F				residents on the care unit were interviewed and all state		
	Resident Als of	linical record was			medications given to them ony	by	
					nurses and QMA's. C.N.A.'s a		
	reviewed on 3/	/22/2011 at 4:55 PM.			other nurses who work the uni interviewed and all but one sta		
					have not given meds or left me		
	Resident A's d	iagnoses included,			for an aide to place. Nurse		
	but were not li	mited to, congestive			disciplined and reinserviced.He		
	heart failure, d	lepression, and			will other residents affected by same deficient practice be	the	
	osteoarthritis p	1 /			identified and what corrective		
	osteourtinitis p	, will.			action(s) will be taken?All		
	Dogidant Alam	hygigian's ardams for			residents receiving medication		
	_	hysician's orders for			have the potential to be affected No other residents were affect.		
	· ·	2011 indicated an			by the practice. DON/designed		
		oderm (used to			will monitor by observation and	d	
	relieve pain) 5	% patch to (R) (right)			resident interviews daily for 4 weeks or until resolution occur	.	
	hip @ HS. Off in AM."				then randomly. Inservicing was		
					done on 3/23/11 and is ongoin		
					on the facility medication		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155206		LDING		03/25/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER			1	ORNADAY ROAD		
	SBURG HEALTH CA	ARE CENTER		1	NSBURG, IN46112	_	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	,	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
IAG		nted Resident A was		IAG	administration policy.What		
	interviewed or	n 3/22/2011 at 6:18			measures wil be put into place and waht systemic changes w	I	
		cated she had a pain			be made to ensure the deficien		
		a's would put on her			practice does not recur?Staff		
	_	when she went to bed			inservicing was done on 3/23/ and is ongoing on the facility	11	
	_				medication administration police	cy	
		rrse was "too busy" to			for licensed nurses and QMA's		
	*	. She indicated she			C.N.A.'s were also inserviced not give medication even if told		
	`	get anyone in trouble			by a nurse. DON/designee will		
	for doing this.		check daily for 4 weeks or until				
					resolution occurs by direct observation and resident		
	During an interview at 8:25 PM, on				interview that are in compliance	e.	
	3/22/2011, wit	th CNA #3, she			How will the corrective action(s	s)	
	indicated the n	urse always puts			be monitored to ensure the deficient practice will not recur	· ie	
	Resident A's p	ain patch on her.			what Quality Assurance Progra	I	
		-			will be put into place and the		
	During an inte	rview at 8:26 PM			completion date?DON/designe will monitor daily for 4 weeks of	I	
	_	ne indicated she			until resolution occurs then		
	would pass Re				randomly by observation and resident interview that are in		
	•	ter as the resident			compliance. Any continued		
		er when she went to			concerns will be addressed in	the	
		cated she would place			monthly Quality Assurance Meeting via a written action pla	an.	
		pain patch when she			The plan will be monitored by	the	
	_	ound 10 PM. She			Administrator/DON/designee u	ıntil	
		etimes the CNA's			resolution occurs.		
	_	ne resident's pain					
	*	e left it in the room					
	_	ace it on the resident					
	once she got in	nto bed. She					
					ļ		

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	or correction	155206	A. BUILDING		03/25/2011	
			B. WINGSTREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER		1010 ⊢	IORNADAY ROAD		
BROWN	SBURG HEALTH CA	ARE CENTER	BROW	NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE COMPLETION DATE	
		would leave the pain				
		sident's bedside and				
	some of the					
	CNA's would	place it on the				
	·	indicated if the CNA				
	was not comfo	ortable placing the				
		n she would place it.				
		CNA #3 had never				
	placed the pair	n patch, but she				
		who might have				
	placed the pair	n patch. She				
	indicated that	none of those CNA's				
	were QMA's (qualified medication				
	aides).	•				
	,					
	Review of the	job description for				
	charge nurse p	provided by the MDS				
	coordinator on	3/25/2011 at 10:25				
	AM, indicated	the nurse was to				
	"Prepare and a	administer				
	medications as	s ordered by the				
	physician."					
	Review of the	job description for				
	the Certified N	Nursing Assistant				
	provided by th	ne MDS coordinator				
	on 3/25/2011 a	at 10:25 AM,				
	indicated the C	CNA had no				
				1		

l	OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	A. BUILDING			COMPI 03/25/2	LETED
	PROVIDER OR SUPPLIER SBURG HEALTH C		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE DRNADAY ROAD ISBURG, IN46112	1	
BROWN: (X4) ID PREFIX TAG	Review of the "Medication A General Guide the MDS coor at 10:25 AM, is person who pradministration administers the	ratement of deficiencies CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) ministration duties. 2007 policy for dministration elines" provided by dinator on 3/25/2011 indicated "5. The epares the dose for is the person who e dose"				ATE	(X5) COMPLETION DATE
	This federal ta IN00087244. 3.1-35(g)(1)	g refers to complaint					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155206	B. WING			03/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			1010 H	ORNADAY ROAD		
	SBURG HEALTH CA				NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	· · · · · · · · · · · · · · · · · · ·	_	DATE
F0282	Based on recor		F028	82	What corrective action(s) will be accomplished for those reside		04/15/2011
SS=D		facility failed to			found to be affected by the		
		an's orders by calling			deficient practice?It is the police of the facility that services be	СУ	
		ordered for 1 of 3			provided by a qualified person	per	
	residents with	insulin injections in a			the resident's plan of		
	sample of 12 (Resident B).			care.Resident #B had an occurence of low blood sugar	on	
					3/9/11. The nurses note did no		
	Findings inclu	de:			state that the physician had be		
					called per the plan of care, cal orders and for a change in	ı	
	1 Resident B's	s clinical record was			conditon. However, it was on t	he	
					24 hour nurses report with a		
		/22/11 at 5:38 P.M.			notation of no new orders.A		
	and again on 3	/23/11 at 1:30 P.M.			late entry to the record has be made to reflect this information		
					Staff have been inserviced from		
	Resident B's d	iagnoses included,			3/23/11 and ongoing to docum		
		mited to insulin			in the medical record that the		
		petes, deep vein			physician has been notified pe	r	
	_	-			the call orders, change in condition and resident plan of		
	thrombosis, de	<i>'</i>			care; and the response to the		
	hypertension,	COPD (chronic			notification.How will other		
	obstructive pu	lmonary disease), and			residents affected by the same	,	
	Parkinson's dis	sease.			deficient practice be identified and what corrective action(s) v	vill	
					be taken?All residents have th		
	Review of Res	sident B's nurses			potential to be affected by the		
					practice. Staff have been		
	notes indicated				inserviced on 3/23/11 and ongoing to documenting		
		10:00 P.M., "@ (at) 4			physician notification and		
	P Writer entere	r entered res. room & found			documenting in the chart. Also		
	res. unrespons	ive & diaphoretic.			inserviced to calling for change		
		gar) 41. Res was			conditon, results outside of cal order parameters or plan of ca		
	given 2 cups vanilla pudding & 120				DON/designee will monitor for		
	given 2 cups v	anna pudung & 120			changes through the 24 hour		

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		155206	1	LDING		03/25/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ORNADAY ROAD		
BROWN	SBURG HEALTH CA	ARE CENTER			NSBURG, IN46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION		
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE .	
	cc (cubic centi	meters) Ensure over			nurses report on a daily basis will monitor for documentation		
	45 min. (minu	te) time frame. B/S			call order and plan of care	,	
	gradually rose to 72 and res became				changes. No other resident we	ere	
	-	name. Skin was			affected by this practice.What	l l	
	•				measures will be put into place		
		cked speakers c			and what systemis changes w be made to ensure that the		
	(with) eyes &	answered questions			deficient practice does not		
	appropriately -	- 4 P insulin held.			recur?Staff inservicing was do	ne	
	* * *	d 75% of supper c			on 3/23/11 and is ongoing on		
		* *			physician notification, call orde	-	
	(with) 240 cc fluid intake. 9P B/S				plan of care and documentation of the information in the reside		
	261. HS (bedtime) insulin				chart. DON/designee will mon		
	administered a	s ordered."			daily by checking the 24 hour		
					nurses reports and monitoring	of	
	Review of the	physician's orders for			the resident record, plan of ca	re	
		idicated an order for			and documentation to reflect		
					changes/no changes from the physician notification.How will		
	"Accu-chek (fi	ingerstick blood			corrective action(s) be monitor		
	sugar testing)	7 A, 11 A, 4 P, 9 P,			to ensure the deficient practice	l l	
	Call if $B/S < 0$	less than) 60 or >			will not recur, ie, what Quality		
	(greater than)				Assurance Program will be pu	t	
	(greater than)	300.			into place and the completion date?DON/designee will monit	tor	
					the 24 hour nurses report, nev		
	The nurses' no	tes lacked any			orders and MARS/TARS daily		
	notation of the	physician being			any changes. Plan of care will	l l	
	notified of the	resident's low blood			updated to reflect any change		
	sugar as order				Any continued concerns will be addressed in the monthly Qua		
	sugai as blucit	ou.			Assurance Meeting via a writte	·	
					action plan. The plan will be		
	Review of the	care plan, dated			monitored by the		
	12/24/2010, fo	or the problem of			Administrator/DON/designee t	ill	
	"Potenial (sic)	for unstable blood			resolution occurs.		
	sugar levels du						
	sugai ieveis ut	ic to mounn					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206			(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		STREET A 1010 H	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD NSBURG, IN46112	I		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	goal of "Blood between 70 and free of s/s (sigh hypo/hypergly approaches incomplimited to, " signs/sympton extremes: diagraps speech, confus agitation, and abnormals. Insulation of N at 2:45 PM, shiphysician should but she did not called.	cluded, but were not Monitor for ns ob blood sugar phoresis, slurred sion, drowsiness,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155206	B. WING			03/25/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1010 H	IORNADAY ROAD		
	SBURG HEALTH CA				NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG		OR LSC IDENTIFYING INFORMATION)		TAG	ļ	_	DATE
F0328		rvation, record	F03	28	What corrective action(s) will be accomplished for those reside		04/15/2011
SS=D		erview, the facility			affected by the deficient		
		n orders for oxygen			practice?It is the policy of the facility that residents receive		
	for 1 resident,	failed to follow			proper treatment and care for	the	
	orders for oxy	gen for 1 resident,			following special services:		
	failed to ensur	e oxygen			injections; parenteral and ente fluids; colostomy; ureterostom		
	humidification	for 1 resident for 3			ileostomy care; tracheostomy	•	
	of 4 residents	with oxygen therapy			care; tracheal suctioning; rspiratory care; foot care; and		
	in a sample of	12 (Residents B, C,			prosthesis.Resident #B had		
	and J).				oxygen place as a nursing		
					measure per the request of his		
	Fi., 4i., i., .1.,	1			son on 3/15/11 for comfort. Th		
	Findings inclu	de:			resident continued on oxygen greater than 24 hoyurs without		
					obtaining a physicians order to)	
	1. During the f	facility tour with LPN			continue the oxygen. A physic	ians	
	#1, on 3/22/11	at 2:50 P.M., she			order was obtained and the resident continues on oxygen.		
	indicated Resi	dent B had a			Staff inservicing was done on		
	diagnosis of di	iabetes. He had			3/23/11 and is ongoing to facili	•	
	_	was being delivered			Oxygen Administration Policy		
		<u> </u>			that oxygen cannot be continu as a nursing measure for more		
	by nasal cannu	IIa.			than 24 hours.Resident #C ha		
					an order for oxygen a 3 liters p	er	
	Resident B wa	s observed on			nasal cannula continously. The	е	
	3/24/2011 at 9	:10 A.M., lying in			resident would remove his oxygen and would adjust the c	liale	
		en being delivered at			due to confusion. The resident		
	2 liters per nas				soxygen has now been		
	2 mors per mas	our cummunu.			discontinued as his respiratory	′	
	D 11 (D)	1 1 1			status has improved. Staff inservicing was done on 3/23/	11	
		linical record was			and is ongoing on oxygen	11	
	reviewed on 3/22/11 at 5:38 P.M.				administration policy and to		
	and again on 3	3/23/11 at 1:30 P.M.			continously check resident to		
					ensure the oxygen is on the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155206	B. WIN			03/25/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			ORNADAY ROAD		
BROWN	SBURG HEALTH C	ARE CENTER		1	NSBURG, IN46112		
					t		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· `	ICY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
					setting are correct.Resident #. was checked and the oxygen	,	
	Resident B's diagnoses included,				water bottle had approximatel	v	
	but were not limited to insulin				3-4 ounces of liquid still in the		
					bottle. The oxygen bottle is		
	_	betes, deep vein			changed when the fluid level is	S	
	thrombosis, de	ementia,			low and the oxygen tubing is		
	hypertension.	COPD (chronic			changed every 72 hours.		
	1 **	Imonary disease), and			Inservicing was done from 3/23/11 on the oxygen		
	1 *	• //			administration policy, filling of	the	
	Parkinson's di	sease.			oxygen water bottles and		
					changing of the oxygen tubing	-	
	Review of Resident B's nurses				DON/designee will check oxyg	gen	
	notes indicate				water bottles daily on rounds t		
					ensure have fluid in them.How		
	03/10/2011 at	6:00 A.M., "BS 274,			will the other residents affecte	-	
	BP 135/69, P	80, R 40 (normal			the same deficient practice be identified and what corrective		
	respiratory rat	e is 14-18 breaths per			action(s) will be taken?No other	er	
		_			esidents were affected by the		
		5 O2 78% (oxygen			practice. All residents receivin	g	
	saturation leve	el) [normal levels of			oxygen have the potential to b		
	oxygen satura	tion are 92%-100%].			affected. DON/designee and ι		
	NC (nasal can	nula) in place running			nurses will monitor oxygen wa bottles for fluid level and will	ter	
	1				monitor for resident compliance	:e	
	at 3L (liters).				with wearing oxygen as ordere		
	discomfort. R	esident is alert with			and that the settings are corre		
	signs of diaph	oresis. Skin is cool to			DON/designee will monitor		
	1 -	ontinue to monitor."			through observation, checking		
	13 4511.	The state of the s			new orders and 24 hour repor		
	00/10/2011	10.00 1 37 "			residents on oxygen and for a physicians order for the oxyge		
	03/18/2011 at 10:30 A.M.,"O2 Sat on 2 L per N/C (nasal				Monitoring will be daily for		
					DON/designee and each shift	for	
	cannula)"				unit nurses. Inservicing was de		
					on 3/23/11 and is ongoing on		
	00/04/5044				oxygen administration policy a		
	03/21/2011 at	1:00 P.M., "Clear			monitoring of fluid level in water bottle, and that resident is	er	
					Dollie, and that resident is		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPLETED	
		155206	B. WIN			03/25/2	011
		II.	P. (12)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	8			ORNADAY ROAD		
BROWN	SBURG HEALTH C	ARE CENTER			NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION DATE
IAG		·	+	IAU	· · · · · · · · · · · · · · · · · · ·		DATE
	breath sounds.	. O2 Sat. 97%"			compliant with oxygen as ordered, as well as having a		
					physician's order in place if is		
	Review of all	of the physician's			used for more than 24		
		rch 2011 indicated the			hours.What measures will be p	out	
					into place and what systemic		
	lack of an ord	er for oxygen			changes will be made to ensur		
	administration	1.			that the deficient practice does		
					not recur?Inservicing was don from 3/23/11 and ongoing on	-	
	During on into	orgiony with I DNI #4			oxygen administration policy,		
	1	erview with LPN #4			oxygen water bottle fluid levels	3,	
	(ADON #1) of	n 3/23/2011 at 4:59			resident compliance with oxyg	en,	
	P.M., she indi	cated oxygen could			checking the correct setting ar	nd	
	be administere	ed to residents as a			obtaining a physician order if		
					used for more than 24 hours a nursing measure.DON/designe		
	1	are and a physician's			will check daily for new orders		
	order was not	needed.			the 24 hour report and by		
					reviewing new orders. Will also	o	
	2 During the	e facility tour on			check oxygen water bottle fluid		
	_	2:46 P.M., with RN			level and for resident compliar		
		· ·			diring daily rounds. Unit nurses will check every shift for	S	
		C was not identified as			compliance and water levels.	low	
	needing oxyge	en.			will the corrective action(s) be		
					monitored to ensure the deficie		
	Resident C w	as observed on			practice does not recur, ie, wh		
					Quality Assurance Program wi be put into place and the	II	
		3:05 P.M. He did not			completion		
	have oxygen of	on at this time.			date?DON/Designee/unit nurs	es	
					willmonitor daily(every shift for		
	Resident C wa	as observed on			unit nurses), the fluid level in the		
	3/24/2011 at 10:55 A.M., with			water bottles, for correct settin			
		· · · · · · · · · · · · · · · · · · ·			and resident compliance as we as th e24 hour report and all n		
	oxygen on at a	3.5 liters per minute.			orders. Any continued concerr		
					will be addressed in the month		
	Resident C's c	linical record was			Quality Assurance Meeting via		
					written action plan. The plan w	/ill	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING		ONSTRUCTION	(X3) DATE COMPI 03/25/2	LETED		
	PROVIDER OR SUPPLIER		1010 H	ADDRESS, CITY, STATE, ZIP CODE IORNADAY ROAD INSBURG, IN46112	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
PREFIX	Resident C's d but were not li hypertension, dementia, and Resident C's F physician order for continuous Liters per nasa was not change	cy must be perceded by full LSC identifying information) /22/11 at 7:05 P.M. iagnoses included, mited to, multiple myeloma,	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE	E RIATE	COMPLETION

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155206	B. WING			03/25/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				ORNADAY ROAD		
BROWNS	SBURG HEALTH CA	ARE CENTER			NSBURG, IN46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)		DATE
F0328	3. A current unda	ated facility policy	F03	28	What corrective action(s) will b		04/15/2011
SS=D	provided by the A	Assistant Director of			accomplished for those reside	nt	
00 D	Nursing on 03/24/11 at 8:45 A.M.,				affected by the deficient practice?It is the policy of the		
	_	to "refill humidifier			facility that residents receive		
		(oxygen) regulator daily			proper treatment and care for	the	
					following special services:		
	with sterile distilled water to the line indicated on the bottle or use prefilled				injections; parenteral and ente	ral	
		bottle or use prefilled			fluids; colostomy; ureterostom;	y or	
	bottles"				ileostomy care; tracheostomy		
					care; tracheal suctioning;		
	Resident J's record was reviewed on 03/25/11 at 9:55 A.M. Diagnoses included				rspiratory care; foot care; and prosthesis.Resident #B had		
					oxygen place as a nursing		
	but not limited to	o: COPD (chronic			measure per the request of his	3	
	obstructive pulm	onary disorder), CHF			son on 3/15/11 for comfort. Th		
	_	t failure), hypoxia, and			resident continued on oxygen	for	
	macular degenera				greater than 24 hoyurs without		
	maculai degenera	ation.			obtaining a physicians order to		
	3.5.11.1.1.1.1				continue the oxygen. A physic	ians	
		istration Recap, dated			order was obtained and the		
		ted a physicians order for			resident continues on oxygen. Staff inservicing was done on		
	2 liters of continu	uous oxygen per nasal			3/23/11 and is ongoing to facili	tv	
	cannula to mainta	ain oxygen saturation			Oxygen Administration Policy		
	above 90%.				that oxygen cannot be continu		
					as a nursing measure for more		
	There were no ni	nysician orders indicating			than 24 hours.Resident #C ha		
		the oxygen tubing or			an order for oxygen a 3 liters p		
	_	les on the humidifier.			nasal cannula continously. The resident would remove his	9	
	sterne water bott	ies on the numidifier.			oxygen and would adjust the d	liale	
					due to confusion. The resident		
		desident J's room on			soxygen has now been		
	03/24/11 at 9:05	A.M., indicated an			discontinued as his respiratory	,	
	undated empty be	ottle of sterile water on			status has improved.Staff		
	his O2 regulator.				inservicing was done on 3/23/	11	
					and is ongoing on oxygen		
	An interview with LPN #2 on 3/24/11 at				administration policy and to		
		ated "the bottles are			continously check resident to ensure the oxygen is on the		
	7.13 11.1VI., IIIdici	area the bothes are			Should the oxygen is on the		
			1		İ		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		155206	B. WING		03/25/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP CODE	•
				ORNADAY ROAD	
BROWN	SBURG HEALTH CA	ARE CENTER	BROW	NSBURG, IN46112	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
	usually changed	by night shift with the		setting are correct.Resident #	J
	tubing every seven days."			was checked and the oxygen	
				water bottle had approximatel 3-4 ounces of liquid still in the	•
	This federal tag i	refers to complaints		bottle. The oxygen bottle is	
	IN00087244 and	-		changed when the fluid level i	s
	11100007244 and	11100007407.		low and the oxygen tubing is	
	2.1.47(a)(()			changed every 72 hours.	
	3.1-47(a)(6)			Inservicing was done from	
				3/23/11 on the oxygen	
				administration policy, filling of	tne
				oxygen water bottles and changing of the oxygen tubing	,
				DON/designee will check oxygen	
				water bottles daily on rounds	
				ensure have fluid in them.Hov	
				will the other residents affecte	d by
				the same deficient practice be	;
				identified and what corrective	
				action(s) will be taken?No oth	er
				esidents were affected by the practice. All residents receivir	n
				oxygen have the potential to b	-
				affected. DON/designee and	
				nurses will monitor oxygen wa	
				bottles for fluid level and will	
				monitor for resident compliand	•
				with wearing oxygen as order	I
				and that the settings are corre DON/designee will monitor	;cl.
				through observation, checking	of
				new orders and 24 hour repor	•
				residents on oxygen and for a	
				physicians order for the oxyge	en.
				Monitoring will be daily for	
				DON/designee and each shift	
				unit nurses. Inservicing was d on 3/23/11 and is ongoing on	OHE
				oxygen administration policy a	and
				monitoring of fluid level in wat	
				bottle, and that resident is	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155206			(X2) MULTIPLE CO A. BUILDING B. WING	COMPI	(X3) DATE SURVEY COMPLETED 03/25/2011	
	ROVIDER OR SUPPLIER		STREET . 1010 H	ADDRESS, CITY, STATE, ZIP CODE IORNADAY ROAD NSBURG, IN46112		
	SBURG HEALTH CA SUMMARY S (EACH DEFICIEN		STREET . 1010 H	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY) compliant with oxygen as ordered, as well as having physician's order in place used for more than 24 hours. What measures will into place and what syster changes will be made to ethat the deficient practice not recur? Inservicing was from 3/23/11 and ongoing oxygen administration poloxygen water bottle fluid livesident compliance with checking the correct settir obtaining a physician order used for more than 24 hoursing measure. DON/dewill check daily for new or the 24 hour report and by reviewing new orders. Will check oxygen water bottle level and for resident comdiring daily rounds. Unit now will check every shift for compliance and water level will the corrective action (smonitored to ensure the difference of the put into place and the completion date? DON/Designee/unit willmonitor daily (every shi unit nurses), the fluid level water bottles, for correct sand resident compliance as and resident compliance and resident com	g a if is I be put mic ensure does done on icy, evels, oxygen, ag and er if urs as a signee ders on I also e fluid apliance urses els.How e) be deficient e, what m will nurses ft for I in the settings as well	(X5) COMPLETION DATE
				as th e24 hour report and orders. Any continued cor will be addressed in the m Quality Assurance Meeting written action plan. The pl	ncerns nonthly g via a	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206			(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/25/2011	
	PROVIDER OR SUPPLIER		STREET 1010 H	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD	<u> </u>
	SBURG HEALTH CA			NSBURG, IN46112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
IAU	REGULATORI OK	LOC IDENTIFY THYO INFORMATION)		be monitored by the Administrator/DON/ designee until resolution occurs.	DATE

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPL	ETED
		155206	B. WIN			03/25/2011	
			D. ((11)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			l	ORNADAY ROAD		
BROWNS	SBURG HEALTH CA	ARE CENTER		l	NSBURG, IN46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	ļ	TAG	DEFICIENCY)		DATE
F0431		ervation, record	F04	31	What corrective action(s) will be accomplished for those rsiden		04/15/2011
SS=D	review, and interview, the facility				found to be affected by the		
	failed to ensure a medication cart				deficient practice?No residents were affected by the deficient	8	
	and treatment	cart were locked			practice.The 400 hall treatmen	ıt	
	when not in us	se on 2 of 8 halls.			cart was found to be unlocked		
	This practice h	nad the potential to			3/22/11 on 3 separate occassi with the nurse not at the cart.		
	affect 32 resid	ents in the facility			LPN assigned to 400 hall has	1116	
	population of	130. (200 hall			been terminated due to this be	ing	
	medication car	rt and 400 hall			addresssed with him on a		
					previous occassion. Staff inserviced on 3/23/11 and		
	treatment cart)).			ongoing to medication		
					administration policy and that		
	Findings inclu	de:			medication and treatment carts	s ar	
	G				eto be locked at all times if		
	1 The 400 ha	ll treatment cart was			nurse/QMA is not at the cart.T 200 hall medication cart was	he	
					found unlocked on 3/23/11. RN	, l	
		/22/2011 at 5:30 PM,			was disciplined. Stated she wa		
		8:20 PM. It was			just inside the door of the roon		
	unlocked during	ng all observations.			but cart was not within her sigle Staff inserviced on 3/23/11 and		
	There was no	staff or residents near			ongoing to facility medication	_	
	the cart during	geach observation.			administration policy and carts	to	
	the cart daring	, caen observation.			be locked at all times when		
					nurse/QMA not present.How	.	
	2. The 200 ha	ll medication cart			willothe residents affected by t	he	
	was observed	with LPN #2 on			same deficient practice be identified and what corrective		
	3/23/3011 at 1	2:01 PM. The			action(s) will be taken.All		
					residents have the potential to	be	
		rt was not in use, but			affected. Nio resident was		
	was in the hall	way and was not			affected by the practice.		
	locked. LPN # 2 said, "It should have been locked and locked it."				Inservicing was done on 3/23/		
					and is ongoing on the medicat	ion	
	110,0000111001	To a mile to once it.			administration policy and the importance of locking the cart		
					when not in sight of the		
					I		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL 03/25/2	ETED	
		100200	B. WIN			00/20/2	011
NAME OF I	PROVIDER OR SUPPLIEI	3		1	ADDRESS, CITY, STATE, ZIP CODE		
	SBURG HEALTH C	_			ORNADAY ROAD NSBURG, IN46112		_
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG		2007 policy for	+	IAU	nurse/QMA.What measures w	ill	DATE
		Administration			be put into place and what		
					systemic changes will be madensure that the deficient practi		
		elines" provided by			does not recur?Staff inservicir		
	the MDS coor	dinator on 3/25/2011			donme on 3/23/11 and ongoin	-	
	at 10:25 AM,	indicated "17.			on facility medication		
	During admin	istration of			administration policy. DON/designee will check carts	,	
	medications t	he medication cart is			daily at different times for 4	•	
	· · · · · · · · · · · · · · · · · · ·	nd locked when out of			weeks or until resolution then		
	_	edication nurse. No			randomly to monitor		
	~				compliance.How will thew corrective action(s) be monitor	od.	
		re kept on top of the			to ensure the deficient practice		
	cart. The cart	must be clearly			will not recur, ie, what Quality		
	visible to pers	onnel administering			Assurance Program will be pu	t	
	medications w	hen unlocked"			into place and the completion date?DON/designee will monit	or	
					daily at different times for 4	.01	
	 This federal ta	ng relates to complaint			weeks or until resolution then		
	IN00087244.	.8 returns to comprise			randomly to ensure compliance Any continued concerns will be		
	11100007244.				addressed at the monthly Qua		
					Assurance Meeting via a writte		
	3.1-25(m)				action plan. The plan will be		
					monitored by the	until	
					Administrator/DON/designee un resolution occurs.	ırıtıı	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITH	DDIC		COMPL	ETED
		155206	A. BUII B. WIN			03/25/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER				ORNADAY ROAD		
BROWNS	SBURG HEALTH C	ARE CENTER		1	NSBURG, IN46112		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	T	ID	DROUIDERIG N. AV OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPRO	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
F0441	Based on obse	rvation, interview,	F04	41	What corrective action(s) will be		04/15/2011
SS=D	and record rev	iew, the facility			accomplished for those reside found to be affected by the	nis	
	failed to have	signs posted for 1			deficient practice?It is the police		
	resident in isolation and supplies in				of the facility that it maintains a Infection Control Program that		
	the carts at the doorways of 2				provides a safe, sanitary and	•	
	residents in isolation for 3 residents				comfortable environment to he	elp	
					prevent the development and		
		a sample of 12			transmission of disease and		
	(Residents C a	and L).			infection.Resident #C was admitted with C-Diff. He had a	n	
	Findings included:				isolation cart outside his room		
					The signage was missing from	ı	
					the door on tour, It was		
	1 Design 41.	6:1:44			immediately replaced. There v	vere	
	_	facility tour on			no gowns in the cart but they were accessible in the hallway	,	
	3/22/2011 at 2	:46 P.M., with RN			closet. Facility policy says a go		
	#1, Resident C	was identified as			is worn if you think you may so	oil	
	being in isolat	ion for C.diff. The			your clothes. Gowns were place		
	door and the c	art in front of the			in the isolation cart drawers. T resident is incontinent and we		
		y sign to indicate the			a brief. Resident was still on	o o	
					Vancomycin at the time so a		
		n isolation or to see			repeat culture could not be do	ne.	
	the nurse before	re entering the room.			Resident is currently out of isolation after returning from the	ne l	
	There was a st	aff member who			hospital(had Permacath remov		
	didn't have a g	own on in the room			The hospital noted that the	·	
	_	ent during this tour.			resident has loose stools but r		
		o was in the hallway			C-Diff. Inservicing was done o 3/23/11 and is ongoing to isola		
		·			procedures for all nursing staff		
	_	r, indicated there			DON/designee will monitor		
	should be a sig	gn on the dresser, but			isolation carts daily to ensure		
	she couldn't fi	nd the sign. She			proper equipment is present a		
	indicated she	lidn't think the			that signage is in place. C.N.A assignment sheets have been		
	resident was still being treated for				updated to reflect to show who		
	resident was s	an oonig neaded for			in isolation.Resident #L return		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPLI 03/25/20	ETED
	PROVIDER OR SUPPLIER SBURG HEALTH CA			STREET A	DDRESS, CITY, STATE, ZIP CODE DRNADAY ROAD NSBURG, IN46112		(X5)
BROWN	SBURG HEALTH CASUMMARY S (EACH DEFICIENT REGULATORY OR C. diff. The cart in fro door was obset 4:30 P.M. The gowns in the difference of the control of the	ARE CENTER TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) Int of Resident C's rved on 3/22/2011 t e cart didn't have any drawers. Ilinical record was /22/11 at 7:05 P.M. iagnoses included, mited to, multiple myeloma,	P	1010 HO	ORNADAY ROAD	n ked or's t of on on fily e is be her on will ded at e iill	(X5) COMPLETION DATE
					equipment, correct signage an aide assignment sheets. DON/designee will monitor	d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155206		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/25/2011			
		100200	B. WING		03/23/2011		
NAME OF I	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE			
	SBURG HEALTH CA		1010 HORNADAY ROAD BROWNSBURG, IN46112				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	isolation carts, signage and air assignment sheets daily for complianceHow will the correct action(s) be monitored to ensut that the deficient practice does not recur, ie, what Quality Assurance Program will be pure into place and the compliance date?DON/designee will monit daily for compliance of correct equipment, signage, isolation policy and aide assignage she Any continued concerns will be addressed in the monthly Quarance Meeting via a writte action plan. The plan will be monitored by the Administrator/DON/designee ure solution occurs.	de stive ure s s s s s s s s s s s s s s s s s s s		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC		COMPL	ETED
		155206	A. BUII B. WIN			03/25/2	011
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIER			l	ORNADAY ROAD		
BROWNS	SBURG HEALTH CA	ARE CENTER		1	NSBURG, IN46112		
					1000110, 114-0112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
F0441		3/25/2011 at 9:40 A.M.,	F04	41	What corrective action(s) will be accomplished for those reside		04/15/2011
SS=D	of Resident C's re	oom indicated an			found to be affected by the	1115	
	isolation cart and	l sign outside of the			deficient practice?It is the police	cv	
	room. The isolati	ion cart contained gloves			of the facility that it maintains		
	and red bags. The	e isolation cart did not			Infection Control Program that		
	contain any prote				provides a safe, sanitary and		
	prote				comfortable environment to he	elp	
	An undated CNA	A assignment sheet			prevent the development and		
					transmission of disease and infection.Resident #C was		
		MDS Coordinator on			admitted with C-Diff. He had a	n	
		A.M., dated 03/23/11,			isolation cart outside his room		
		Resident C was in contact			The signage was missing from	ı	
	isolation.				the door on tour, It was		
					immediately replaced. There v	vere	
	A current undate	d facility policy titled,			no gowns in the cart but they		
	"Isolation" provi	ded by the MDS			were accessible in the hallway		
	•	03/25/11 at 10:15 A.M.			closet. Facility policy says a go is worn if you think you may so		
		on precautions will be			your clothes. Gowns were place		
		ysician order, or per			in the isolation cart drawers. T		
		Director of Nursing,			resident is incontinent and wea	ars	
		<u> </u>			a brief. Resident was still on		
	Assistant Directo	•			Vancomycin at the time so a		
		a precautionary measure.			repeat culture could not be do	ne.	
		ndicated the facility will			Resident is currently out of isolation after returning from the	10	
	"make sure car	t is stocked with			hospital(had Permacath remov		
	appropriate equip	oment."			The hospital noted that the		
					resident has loose stools but r	not	
	A current undate	d facility policy titled,			C-Diff. Inservicing was done o		
		ased Precautions"			3/23/11 and is ongoing to isola		
		MDS Coordinator on			procedures for all nursing staff	r.	
		5 A.M., indicated staff			DON/designee will monitor isolation carts daily to ensure		
		*			proper equipment is present a	nd	
	_	own when entering a			that signage is in place. C.N.A		
	•	cipate soiling or clothing			assignment sheets have been		
	from resident or	environment."			updated to reflect to show who		
					in isolation.Resident #L return	ed	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE (COMPL 03/25/2	ETED
		133200	B. WIN			03/23/2	011
NAME OF I	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD		
_	SBURG HEALTH C	-			NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	_	DATE
		ecord was reviewed on			from the hospital on 3/24/11 of the 3/11 shift. Carts were stock		
		0 A.M., diagnoses			with gowns and all equipment.		
		re not limited to C-Diff,			Signage was placed on the do		
	dehydration, atri				C.N.A. assignment sheet was		
	malnutrition, hyp	pothyroidism, lower			updated on 3/25/11 and C.N.A		
	extremity edema	, and thrombocytopenia.			received verbal report till shee		
					was updated on the morning of 3/25/11. Inservicing was done		
	Physician admis	sion orders dated			3/23/11 and ongoing on isolati		
	I -	ed Resident L was			policy for all nursing staff.	•	
		the hospital with C-Diff.			DON/designee will monitor da	ily	
	disentinged from	the hospital with C Diff.			to ensure cart is stocked with		
	Nurses notes dated 03/24/11 at 10 P.M.,				equipment and correct signage		
		-			in place. Assignment sheets for		
		nt L was in contact			aides wil be updated with new changes. How will other reside		
	isolation for C-E	Oiff.			affected by the same practice		
					identified and what corrective		
	Observation of F	Resident L's room on			action(s) will be taken?All		
	03/25/11 at 9:45	A.M., indicated a sign			residents have the potential to		
	and isolation ca	rt outside the residents			affected by the practice. No ot		
	room. The isolat	ion cart contained gloves,			residents were affected by the practice. Inservicing was done		
	masks, red and y	rellow bags. The isolation			3/23/11 and is ongoing on	OH	
	cart did not cont	ain any protective gowns.			isolation policy and proper		
		31 8			signage and stocking of the		
	Interview with C	CNA #1 on 03/25/11 at			isolation carts. DON/designee	will	
		ated "I don't know why			monitor carts daily for proper	had	
		. I have been off for a			equipment, signage and update C.N.A. assignment sheets.Wh		
					measures will be put into place		
		sk someone before I went			and what systemic changes w		
		ded a gown, I would get			be made to ensure that the		
		ones, if there were none			deficient practice does not		
	in the dresser."				recur?Staff inservicing was do	ne	
					on 3/23/11 and is ongoing on isolation policy, proper		
	Interview with L	PN #3 on 03/25/11 at			equipment, correct signage ar	nd	
	9:50 A.M., indic	ated "CNA's are told			aide assignment sheets.	.~	
	who is in isolation	on and why by their CNA			DON/designee will monitor		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			SURVEY	
, and that	or conduction	155206		LDING		03/25/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			1	ORNADAY ROAD		
	SBURG HEALTH CA			1	NSBURG, IN46112		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION DATE
IAG			-	IAG			DATE
	assignment sheet Interview with the 3/25/11 at 10:15 update the CNA athere are changes Interview with C 10:55 A.M., indicate residents that here in the facilit Interview with the 03/25/11 at 12:30 unit managers are updating the CNA needed and they An updated CNA provided by the 103/25/11 at 9:55 did not indicate It isolation.	is". In the MDS Coordinator on A.M., indicated "We only assignment sheets when is". In the MDS Coordinator on a construction of the MDS Coordinator on the MDS Coordinator on the MDS Coordinator of the MDS			isolation carts, signage and aid assignment sheets daily for complianceHow will the correct action(s) be monitored to ensut that the deficient practice does not recur, ie, what Quality Assurance Program will be purinto place and the compliance date?DON/designee will monit daily for compliance of correct equipment, signage, isolation policy and aide assignage she Any continued concerns will be addressed in the monthly Qua Assurance Meeting via a writte action plan. The plan will be monitored by the Administrator/DON/designee uresolution occurs.	ets.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/25/2011	
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
BROWNS	SBURG HEALTH CA	ARE CENTER		1010 HORNADAY ROAD BROWNSBURG, IN46112		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		